POST-CAESAREAN VESICOUTERINE FISTULA (YOUSSEF’S SYNDROME)

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ABSTRACT
We describe a young woman who developed vesicouterine fistula after cesarean section which was repaired in team work. (Rawal Med J 2010;35: ).

Key words
Vesicouterine fistula, urogenital fistula, cesarean section.

INTRODUCTION
Vesicouterine fistula is a rare condition representing 1-4% of all urogenital fistulas.\(^1\) It is usually related principally to caesarean section (CS).\(^2\) It is likely to occur when there is inadequate mobilisation of the bladder inferiorly and laterally or the bladder might be injured during delivery of a large fetal head or the bladder might be accidentally included in the sutures. The fistula site is typically at the posterior aspect of the bladder dome. The main symptom is urinary incontinence, often occurring immediately after CS if injury to
the bladder is unrecognized or treated inadequately. But patients may present months or years later with cyclic hematuria, amenorrhea and urinary tract infection.³

CASE PRESENTATION

A thirty year old woman (para 3) with previous three CS presented to the Department of Gynecology with history of cyclic hematuria for the past two years. In her last CS in which tubal ligation was also done, bladder was adherent to the lower uterine segment and was separated with difficulty. She had an indwelling urethral catheter for two weeks and did not have any voiding problems after the catheter was removed. Two months later, she started to experience cyclic hematuria with no menstrual blood flow. A cystoscopy showed the fistulous site near the bladder dome and posterior wall. Laparotomy was performed by a team comprising the gynecologist and the surgeon. The approach was transperitoneal. Dissection was carried out between the bladder and uterus around the fistula. The fistulous tract was excised and margins were freshened. The uterus and bladder were closed separately with interrupted sutures in layers. Omental pedicle was interposed between the two suture lines. The bladder was drained with both suprapubic and urethral catheters. The post operative period was uneventful, urethral catheter was removed after two weeks. The results of surgical treatment were excellent with good continence and resolution of the hematuria.

DISCUSSION

Youssef’s syndrome is one of the least common types of urogenital fistula. It is a rare complication of CS following inadvertent bladder injury. In 1957, Youssef described the classic triad of CS, amenorrhea and cyclic hematuria in the absence of urinary incontinence as a syndrome, which is characteristic of vesicoureterine fistula.⁴ The reason
for lack of vaginal leakage of urine might be the sphincteric effect of uterine isthmus as described by Youssef. Vesicouterine fistula is not difficult to diagnose, as clinical examination, cystoscopy, hysterosalpingography and cystogram are sufficient to make the diagnosis. Transvaginal ultrasonography\textsuperscript{5} and MRI have been used.\textsuperscript{6} Different treatment modalities that include conservative approach, fulguration, hormonal therapy and open surgery have been used. Conservative treatment with bladder catheterization for at least 4-8 weeks can be successful when the fistula is recognized early. Endoscopic fulguration and hormonal treatment by estrogen and progesterone induced amenorrhea can be successful for selected small fistulae.\textsuperscript{7} The accepted treatment for large fistulas is surgical and a transabdominal approach is preferred. Total hysterectomy along with repair of the bladder may be considered in multiparous women nearing menopause and when other uterine pathology is present such as fibroids or endometrial dysfunction. Of late, some surgeons are attempting repair by laparoscopic approach.\textsuperscript{8} Successful pregnancies have been reported after surgical repair of vesicouterine fistulas.\textsuperscript{9} Such patients undergo elective CS because of the risk of fistula recurrence. In our case, surgical repair of vesicouterine fistula was the only option because of delayed presentation of the case. Successful outcome was achieved with resolution of cyclic hematuria. Hysterectomy was not considered because there were no dense adhesions and patient was relatively young with no associated uterine pathology.

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REFERENCES


